	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
<u> </u>		15G313	B. WING			03/15/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000000							
			Woo	00000			
	This visit was for	r investigation of	****				
	complaint #IN00	•					
	Complaint #11100	0124020.					
	Complaint #INO	0124626: Substantiated.					
	*	iciencies related to the					
	- ' '	cited at W104, 252 and					
	W331.						
		conjunction with the					
	•	ication revisit) to the					
	•	on $01/25/13$, to the					
	_	complaint #IN00119881					
	completed on 12	/14/12.					
	Dates of Survey:	March 11, 12, 13, 14					
	and 15, 2013.						
	Facility Number:	000832					
	Provider Number	r: 15G313					
	AIMS Number:	100249150					
	Surveyors:						
	Claudia Ramirez	, RN, Public Health					
	Nurse Surveyor	III - Team Leader					
	Vickie Kolb, RN	, BSN, Public Health					
	Nurse Surveyor						
	-						
	These deficiencie	es also reflect state					
	findings in accor	dance with 460 IAC 9.					
	_	npleted 3/26/13 by Ruth					
	Shackelford, Medica	-					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000832

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUILDING B. WING	00	COMPLETED 03/15/2013				
	ROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V6L711

Facility ID: 000832

If continuation sheet Page 2 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		15G313	B. WIN			03/15/2	2013
			D. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE	HEBRON, IN 46341				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000104		DDY ody must exercise general nd operating direction over					
	D 1 1	. 1:7 . 4	W0	00104	This citation is in error. There	le to	04/07/2013
		review and interview, the			were nursing services available to the agency during time specifed.		
		failed to exercise			The surveyor was informed		
		on over the facility to			during the interview that the ne		
		nple clients (clients A, B			was taking calls regarding nur	sing	
	and C), and 2 ad	ditional clients (clients D			issues.		
	and E) had nursi	ng services available to			RN was contracted on 1/26/13 to		
	them, from the agency.				conduct medication administration classes and was available for at time		
					of Nursing Manager's absence if		
	Findings include	:			needed. The Nursing Manager was		
	C				hospitalized from 2/13/13 to		
	On 03/12/13 at 2	2:00 PM a record review			2/15/13. During her absence, she		
		nnel files and nursing			took phone calls in the hospital just		
		of the agency was			like she does when she is home.		
		records indicated the			Director of Community Services	_	
	following:	records indicated the			redistributed non-nursing portion o	f	
	ionowing.				job to other staff and worked directly with the contracted nurse		
	DNI (Danistana d	Name of the state of			and temps to assure services		
		Nurse) #1 was hired			according to the standards, policies		
	01/07/13.	1. 1 1. 1			and procedures. Two LPNs were		
		d indicated she was not			hired on 3/11/13. On 4/8/13, an RN	ı	
		m 02/13/13 after 11:00			was hired as Director of Health		
	AM until 03/04/				Services. One LPN position remains		
	,	Practical Nurse) #1's last			open with a temporary nurse filling		
	day of employm	ent was 01/24/13.			in until a suitable replacement can		
	LPN #2's last da	y of employment was			be found. So at the present time,		
	01/24/13.				The Arc Northwest Indiana employs two RNs, two LPNs, and one temp		
	LPN #3's last da	y of employment was			LPN.		
	02/07/13.	· •					
	A contract with a	an outside provider for			All other homes were affected by		
		services of two LPN's			this dramatic change in nursing		
			1		I		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V6L711

Facility ID: 000832

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G313	B. WIN	IG		03/15/	2013
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			19038 N	MISSISSIPPI ST		
ARC OF	NORTHWEST IND	ANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was signed 02/18				staff. These new nurses will serve 5	4	
	Contract LPN #1	's first day of service to			th and our other group homes. In		
	the agency was (02/19/13.			addition an experienced RN will stay on staff until such time that these		
	Contract LPN #2	2's first day of service to			new nurses are up to speed with all		
	the agency was (02/21/13.			of the clients care.		
	- -						
	On 03/13/13 at 1	1:45 AM an interview			We now have a contract with a		
		conducted. The RN			temporary nursing agency so that		
		s hired by the agency			there is no delay in replacing a nurse	2	
		s currently using the			should one not be able to fulfill their	•	
		tract agency for nursing			job duties.		
	_	ith herself. She indicated			In the absence of the Director of		
		r the agency and was			Health Services, the Director of Community Services was responsible		
		er after hours. She			for assuring policies and procedures		
		nt on sick leave on			and nursing services. The Director of		
	02/13/13 and wa	s in the hospital 2 - 3			Health Services is taking on this		
	days, at which ti	me she did not have a			responsibility and is responsible for		
	pager and was no	ot available to the agency.			future monitoring of nursing		
	She indicated the	e first day the contract			services.		
	LPN #1 worked	was 02/19/13. The RN					
	indicated after sl	ne was hospitalized she					
		from home. She					
	_	s out of the office on					
		om 02/13/13 to 03/04/13.					
		eated there was no nursing					
		to the agency from					
		9/13 for clients A, B, C,					
		7/13 IOI CHEIRS A, D, C,					
	D and E.						
		1					
	_	relates to complaint					
	#IN00124626.						
	9-3-1(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V6L711

Facility ID: 000832

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUILDING B. WING	00	COMPLETED 03/15/2013				
	ROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V6L711

Facility ID: 000832

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G313	B. WIN			03/15/	2013
	ROVIDER OR SUPPLIER			19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)	_	DATE
W000252	483.440(e)(1) PROGRAM DOC Data relative to ac criteria specified i plan objectives m measurable terms Based on record 1 of 3 sampled c facility failed to data outlined in t Plan (ISP). Findings include Client B's record 03/13/13 at 10:14 was dated 03/21/ Repositioning Ri The 12/2012 Rep indicated data was shift, on a daily to 12/2012: Reposi "Reason for the p sores and encour Baseline: [Clien almost all the tim wheelchair or be transferred out or relieve pressure of well as to encour [Client B] should wheelchair to a be	UMENTATION complishment of the n client individual program ust be documented in s. review and interview for lients (client B), the document and/or collect the Individual Support s were reviewed on 4 AM. Client B's ISP 12 and contained a sk Plan dated 12/2012. Positioning Risk Plan as to be collected every	W0	00252	Wound tracking sheets for this client are to be completed daily and faxed in. The actual sheet sent in via interoffice mail wee A nurse will review wound tracking sheets and report any findings to the doctor. The wound care tracking shee and work instructions were revised again on 4/19/13. Who deemed necessary, staff will complete the wound tracking sheet and will fax it into the Community Services Nurse da for review with a hard copy be sent into the office weekly. As stated in W 104 new nursing shave been hired and will be trained on this procedure by 4/22/13. The Director of Health Service in cooperation with the Service Coordinator, will review the Community Services Nurse's records to ensure the wound tracking sheets are being completed and reviewed throu weekly meetings. Any missing sheets will be reported to the appropriate Area Manager who will hold the direct care staff accountable for their failure to complete the form.	y is kly. t en illy gh gh	04/07/2013
	o nomb. ii iio				This procedure will ensure the		

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Event ID: V6L711

Facility ID: 000832

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G313	B. WIN			03/15/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF			19038 N	MISSISSIPPI ST	
	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		and checked for wetness			wound care is being done.	
	every two hoursStaff to monitor on					
		e will monitor daily logs.				
		actions: Staff are to				
		s to their Nurse and				
		ator following every shift				
		lent reports to the service				
		Turse within 24 hours of				
	the incident."					
	Client B's record	l contained skin				
	assessments for	the following dates:				
	03/01, 02, 03, 04	4, 06, 07, 08, 09, 10, 12				
	and 13, 2013. T	he record did not contain				
	skin assessments	s for the following dates:				
), 21, 22, 23, 24, 25, 26,				
		nd 31, 2013, or 02/01, 02,				
		7, 08, 09, 10, 11, 12, 13,				
		8, 19, 20, 21, 22, 23, 24				
	and 25, 2013.	0, 10, 20, 21, 22, 20, 21				
	una 23, 2013.					
	An interview wi	th the RN (Registered				
		/13 at 12:45 PM was				
	· ·	RN indicated according				
		•				
	_	the skin assessments				
		mented every shift and				
		from the home to the				
		eated she did not know				
		being faxed to and there				
		ntation on the skin				
		how that a nurse had				
		She stated client B was at				
	-	blems and pressure sores,				
	therefore "it was	important" the risk plans				

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Event ID: V6L711

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		00	COMPLE S 03/15/2	TED
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST DN, IN 46341	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	be followed.				
	This federal tag relates to complaint #IN00124626.				
	9-3-4(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V6L711

Facility ID: 000832

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			TED	
		15G313	A. BUII B. WIN			03/15/2	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
ADC OF		ANA INC. THE			MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRU	DN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000331	483.460(c)						
	NURSING SERV						
		provide clients with nursing					
	services in accord	dance with their needs.	1770	00001			0.4/0.7/2.010
			WO	00331	New risk plans have been sen		04/07/2013
	Based on record	review and interview, the			out to the house and will contin	nue	
	facility failed for	3 of 3 sampled clients			to be reviewed annually or as needed. To ensure future		
	(clients A, B and	C) and 2 additional			compliance, the agency will		
		and E), by not ensuring			ensure that a nurse is on staff	at	
	`	were available and			all times. RN was contracted of		
	_	and B) received nursing			1/26/13 to conduct medication		
	`	ng to their medical needs.			administration classes and wa		
	services accordin	ig to their medical needs.			available for at time of Nursing		
					Manager's absence if needed.		
	Findings include	:			The Nursing Manager was		
					hospitalized from 2/13/13 to 2/15/13. During her absence,	oho	
	1. On 03/12/13	at 2:00 PM a record			took phone calls in the hospita		
	review of nursin	g personnel files and			just like she does when she is		
		services of the agency			home. Director of Community		
	•	The records indicated the			Services redistributed		
	-	The records indicated the			non-nursing portion of job to of		
	following:				staff and worked directly with t		
					contracted nurse and temps to		
	, ,	Nurse) #1 was hired			assure services according to the standards, policies and	ne	
	01/07/13.				procedures. Two LPNs were		
	RN #1's timecard	d indicated she was not			hired on 3/11/13. On 4/8/13, a	an	
	on the clock from	n 02/13/13 after 11:00			RN was hired as Director of		
	AM until 03/04/	13 at 9:00 AM.			Health Services. One LPN		
		Practical Nurse) #1's last			position remains open with a		
	,	ent was 01/24/13.			temporary nurse filling in until	a	
		y of employment was			suitable replacement can be		
		y of employment was			found. So at the present time, The Arc Northwest Indiana		
	01/24/13.	6 1			employs two RNs, two LPNs, a	and	
		y of employment was			one temp LPN. All other hom		
	02/07/13.				were affected by this dramatic		
	A contract with a	an outside provider for			change in nursing staff. These		
	contract nursing	services of two LPN's			new nurses will serve 54 th an	d	
	was signed 02/18	3/13.			our other group homes. In		

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Event ID: V6L711

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		15G313	B. WIN			03/15/2	2013
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC. THE			N, IN 46341		
					,	775	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	TAG (EACH CONTROLL THE APPROPRIED TO THE APPROPR		COMPLETION DATE
TAG		<u> </u>		addition an experienced RN wil			DATE
		's first day of service to			stay on staff until such time that		
	the agency was (these new nurses are up to sp		
	Contract LPN #2	e's first day of service to			with all of the clients care. We	-	
	the agency was (02/21/13.			now have a contract with a		
					temporary nursing agency so t		
	On 03/13/13 at 1	1:45 AM an interview			there is no delay in replacing a		
		conducted. The RN			nurse should one not be able t	0	
		s hired by the agency			fulfill their job duties. In the absence of the Director of Hea	lth.	
		s currently using the			Services, the Director of	iiu I	
					Community Services was		
		tract agency for nursing			responsible for assuring policie	es	
	_	ith herself. She indicated			and procedures and nursing		
		r the agency and was			services. The Director of Heal	th	
	available by page	er after hours. She			Services is taking on this		
	indicated she we	nt on sick leave on			responsibility and is responsible		
	02/13/13 and wa	s in the hospital 2 - 3			for future monitoring of nursing services.4/26/13		
		me she did not have a			All nurses were trained on the		
	• •	ot available to the agency.			identification and development of		
	^ ~	e first day the contract			risk plans on 4/25/13. Nursing staff		
		was 02/19/13. The RN			and service coordinators will have		
					reviewed all Risk plans for this house	9	
		ne was hospitalized she			by 4/30/13. Revisions will be made		
		from home. She			as necessary. Nursing staff in		
		s out of the office on			conjunction with the Service		
		om 02/13/13 to 03/04/13.			Coordinators will train all staff on		
	She further indic	ated there was no nursing			any new or revised plans by 5/3/13.		
		to the agency from			Training will include staff		
	02/13/13 to 02/1	• •			demonstrating the skills necessary to	0	
					implement the plans. To ensure		
	2 On 02/12/12	at 10:14 AM client B's			continued implementation of the		
					Plans the service coordinator will		
		iewed and contained the			visit the home 2x per month for two months and monthly thereafter.		
	following dated	documents:			The coordinator will document any		
					findings in their case notes. The		
	12/06/12: Cumu	lative Medical Record			behavior health director will audit		
	Notes indicated	client B had a pressure			these case notes monthly for three		
		ck area that was not			months and periodically thereafter.		

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Event ID: V6L711

Facility ID: 000832

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN	G		03/15/2013
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			19038 N	MISSISSIPPI ST	
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	healed.				The nursing staff will also visit the	
					home 2x per month for two	
	12/12: Reposition	oning Risk Plan: "Reason			consecution and monthly thereafter with the added responsibility of	,
	for the plan: To	prevent pressure sores			visually checking/assessing the	
	and encourage m	nuscle movement.			clients. These Nursing checks will	
	Baseline: [Clien	t B] currently spends			be documented in the cumulative	
	almost all the tin	ne he is awake in his			medical record. The director of	
	wheelchair or be	d. He needs to be			health and safety will audit the	
	transferred out o	f his chair and/or bed to			medical records monthly for two	
	relieve pressure	on his back/buttocks as			months and periodically thereafter.	
	_	rage muscle movement.				
		d be transferred out of his				
	_ =	oed, chair, or couch every				
		is in bed for the night, he				
		and checked for wetness				
		Staff to monitor on				
	1 *					
	1	e will monitor daily logs.				
		actions: Staff are to				
		s to their Nurse and				
		ator following every shift				
		ent reports to the service				
		urse within 24 hours of				
	the incident."					
	10/10 5 15 5	DI UD 0 1				
		Plan: "Reason for plan:				
		and safety by reducing				
		Baseline: [Client B]				
		ir at all times due to his				
		Staff need to remind				
		t for assistance in using				
	the toilet or goin	g down ramp in front of				
	home. Staff nee	ds to make sure that				
	[client B] and ba	throom floor are fully				
	dried after show	ering/bathing. Staff need				
		-				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	15G313		LDING	00	03/15/2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				MISSISSIPPI ST	
	NORTHWEST INDI				N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710		t B] for any seizure		1710	<u> </u>	DATE
	_	st him as needed to				
	*	ety." The risk plan failed				
		t B was to use a shower				
		and specifically how and				
	1	chair should be utilized.				
	01/17/13: Cumu	lative Medical Record				
	Notes indicated	client B was discharged				
	from wound clin	ic.				
	Client B's record	contained skin				
	assessments for t	the following dates:				
	03/01, 02, 03, 04	, 06, 07, 08, 09, 10, 12				
	and 13, 2013. T	he record did not contain				
	skin assessments	for the following dates:				
	01/17, 18, 19, 20), 21, 22, 23, 24, 25, 26,				
		d 31, 2013, or 02/01, 02,				
		7, 08, 09, 10, 11, 12, 13,				
		8, 19, 20, 21, 22, 23, 24				
	and 25, 2013.					
	A. n. imtoi	a conducted with the DN				
		s conducted with the RN se) on 03/14/13 at 12:45				
	, · ·	dicated according to the				
		in assessments were to be				
	-	ry shift and were to be				
		ome to the nurse. She				
		I not know where they				
		to and there was no				
	_	n the skin assessments to				
		e had reviewed them.				
		B was at risk for skin				
		essure sores, therefore "it				
	• F	,				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BU		BUILDING 00		COMPLETED		
		15G313		B. WING			03/15/2013	
NAME OF D	BUAIDER OB SHIDDI IED)	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				19038 MISSISSIPPI ST				
ARC OF NORTHWEST INDIANA INC, THE				HEBRON, IN 46341				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAG			DATE	
	was important" the risk plans be followed.							
	She also indicated client B was at risk for							
	falls and should utilize a shower chair.							
	She indicated the risk plan failed to							
	indicate how/when staff were to use the							
	shower chair for showering.							
	3. Client A's record was reviewed on							
	3/14/13 at 1 PM. Client A's record							
	indicated client A's diagnoses included,							
	but were not limited to, Seizure Disorder,							
	Hypertension (high blood pressure),							
	Hyperlipidemia (high cholesterol) and							
	Arthritis. Client A's 7/17/11 ISP							
	(Individual Support Plan) indicated client							
	A did not require a medical care plan.							
	Client A's record indicated Health/Risk							
	Plans (HRPs) in regards to Hyperter							
	Hyperlipidemia, pain related to Arthritis and Seizures. The HRPs indicated the							
	plans had not been reviewed and/or							
	revised by nursing since 7/14/11.							
	Tevised by fluisting since //14/11.							
	Interview with the RN (Registered Nurse)							
	on 3/13/13 at 11:45 AM indicated all							
	HRPs were to be updated annually.							
	This federal tag relates to complaint							
	#IN00124626.							
	0.2.(()							
	9-3-6(a)							

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